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THE UNIVERSITY OF ROCHESTER
SCHOOL OF MEDICINE AND DENTISTRY
AND
STRONG MEMORIAL HOSPITAL
260 CRITTENDEN BOULEVARD
ROCHESTER, NEW YORK 14620

June 28, 1973

RE: [redacted]

Dear Dr [redacted]

Enclosed are the admission and discharge summaries from your patient [redacted] admission to the Clinical Research Center at the University of Rochester. I think the notes are self-explanatory.

It was our feeling that the patient did have idiopathic grand mal epilepsy and should be carried on Dilantin. We did not put him back on his antihypertensive medication because at the time of his discharge, his blood pressures were well within normal range. However, I am certain as in most other cases, his blood pressure will rise again as he resumes his normal activities and probably in the future will require medication of this type. Other than the hypertension and related cardiac changes, the epilepsy and the hemorrhoidal bleeding, we found no evidence of disease in [redacted]

I hope this summary will be of some benefit to you.

Sincerely yours,

Christine W. Waterhouse

Christine Waterhouse, M.D.
Professor of Medicine

CW/dp
Enclosures

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THE UNIVERSITY OF ROCHESTER
STRONG MEMORIAL HOSPITAL

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ADMISSION NOTE: Admitted 6/13/73

The patient is a 62 year old, married, colored male who is admitted to SMH for t first time for balance study of heavy metals.

PRESENT ILLNESS: The patient sustained an injury to his left knee while working for t Pullman Co. outside of Chicago, in 1946. He states that the left knee was crushed at that time and that a year later he was told that he had a tumor of the leg and should have a mid-thigh amputation done. The tumor reportedly was an osteofibromyochrondo sarcoma and he was told at that time that he had less than 5 years to live. He was fitted with an artifical leg following surgery and although he never worked again for t Pullman Co., he has worked at various jobs, perhaps the primary one being shoe repairma During the interval between the amputation and now, he has really had only two problems of any magnitude. He was told that he had high BP 1½ years ago and he has been taking pills of some type for this. He does not know the name of the pills and he has not taken them for a week's time. The other symptom that is present is difficult to evalua According to his wife, he has black-out spells where he does not hear what other people are saying and is out of contact for a few moments. He has never fallen in these, but she feels that he is not aware of what is going on. These have been evident for the pa 2-3 years and perhaps last about 5 minutes. The patient states that they occur when he is angry at someone, particularly his wife and that he really does know what is going c at these times. He has been given some pills by his doctor for these which he says calms down his nerves and lessen the number of "black-out spells".

PAST HISTORY AND ILLNESSES: The patient has had arthritis of particularly his elbows a shoulders for the past several years but this has been without any major deformity or major disability. There have been no other major illnesses - he did have a tonsillecto several years ago and has had no further trouble with sore throats since then.

PERSONAL HISTORY: The patient has worked first as a Pullman Co. employee and later at many odd jobs following the amputation of his left leg. Two years ago, he had a good deal of skin irritation from the artifical leg and stopped wearing the artifical limb at that time. He now goes around on crutches but has been unable to work in the past 2 years. The patient is married. His wife works and he receives Social Security. There are two children.

PHYSICAL EXAMINATION: BP - 160/80. The patient is well nourished and developed and appears to be in good health. He has a mid-thigh amputation of the left leg. There is no jaundice and the skin is clear. The eyes show a very pronounced arcus senilis and the eye grounds show moderate arteriolar narrowing. There is however no AV nicking nor are there any hemorrages and exudates. The disks are flat. The examination of the ear is negative. There is no sinus tenderness. The pharynx is clear. There are no lymph nodes in the neck, axillary or inguinal area. The thyroid is not enlarged. The lungs are clear to P&A. The heart may be somewhat enlarged. I get the left border of cardia dullness about 11 cm. from the mid-sternal line in the 5th interspace. There is consid erable irregularity of the heart beat. Although I do not think he is fibrillating, the must be many extra systoles present. The heart sounds are of good quality however and there are no murmurs. The examination of the abdomen is negative. I cannot feel the liver or spleen or kidneys. The peripheral pulses are good and there is no edema. On rectal, the prostate is of normal size and the stool obtained was guaiac negative.

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FRESSION: #1 - Twenty-five years post chondrosarcoma without evidence of recurrence or metastasis.

#2 - By history, hypertensive cardiovascular disease. By current exam, the only manifestation noted is some irritability of the conduction system.

An EKG will be taken to document the arrhythmia and a chest x-ray will be done to determine precisely heart size.

Christine Waterhouse, M.D.

DISCHARGE SUMMARY: Admitted 6/13/73 Discharged 6/26/73

The admission history and physical examination are enclosed. The white count w 6 and 7.4, the hct. was 44 and 42%, the differential was normal with 6 monocytes, 42 lymphocytes, 1 basophil, 1 eosinophil, and 48 segmented cells. The platelet esti was 4.9/oil immersion field. The urinalysis was negative and the stool guaiac was negative. The chemical screen was normal with a total protein of 6.6, serum albumir 3.3, calcium - 9, phosphorus - 2.9, cholesterol - 174, urea nitrogen - 10, uric acid 4.7, creatinine - 1.1, total bilirubin - .6, alkaline phosphatase - 77, and transami nase - less than 10. The sodium was 140, potassium - 4.2, CO_2 - 26, chloride - 102. The glucose was 88 mg%.

At the time of admission, an EKG was taken which showed frequent atrial prematu contractions with runs of 2 or 3 consecutively. The voltage was diagnostic for a le ventricular hypertrophy with ST abnormalities in 2,3, AVF, V6, which were suggestive strain or ischemia. The cardiac size by chest x-ray was WNL. It was, however, notec that considerable tortuosity of the thoracic aorta was present. There were no pulmor lesions. An incidental finding was calcification of the anterior ligament of the thc spine.

The patient was placed on a atandardized diet and urine and stool collections we carried out. He was asymptomatic until 8 days after his admission at which time he found on the floor unconscious about 11 a.m. Some seizure activity was noted by a doctor on the floor. The patient remained comatose for about 15 min. following this but recovered without sequella gradually thereafter. The BP during the episode was 160/100 and the P was 72. It was our feeling in retrospect that this was one of the "blackout spells" which were described in the initial history. An EEG was taken the following morning and I enclose a copy of this report. A brain scan was also done which was negative. He was started on dilantin following what was probably a grand mal seizure and was given 100 mg. t.i.d. He was told to increase this to 4 times dai if there was further evidence of epileptic seizures.

The only other complication of the patient's hospital admission was the passage of a grossly bloody stool on 6/23. Rectal examination showed no abnormality at that time. He was sigmoidoscoped with negative findings except for hemorrhoids and a barium enema was negative.

DISCHARGE DIAGNOSES:
1. Post chondrosarcoma without evidence of recurrence or metastases.
2. Hypertensive cardiovascular disease
3. Idiopathic epilepsy with grand mal seizure
4. Hemorrhoids with rectal bleeding.

ADDENDUM: The patient's BP throughout his hospital stay showed a diastolic pressure of no greater than 100 and a systolic pressure which was between 120 and 170. There seems to be no doubt of the diagnosis of hypertension but in protected surroundings the BP readings are reasonably good.

Christine Waterhouse, M.D.